

# AMOEBOMA

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AMOEBOMA of the large bowel is a recognized though uncommon variety of amoebiasis. The authors have diagnosed and treated amoebic dysentery frequently in India, but the following case of amoeboma, encountered in Belfast, is the first they have seen here or abroad.

## CASE REPORT

*Present Illness.* On 3rd September, 1967, D.L., a 31 year old Ulsterman, was referred and admitted to Belfast City Hospital with a diagnosis of appendix abscess. He gave a 3 day history of colicky central abdominal pain and a more constant pain in the right abdomen. During this period his bowels had opened 2 or 3 times a day, the motion had been soft, but contained no mucus or blood. He had no nausea, vomiting or urinary symptoms.

*Past History.* In 1954 he had been treated for "dysentery" in Malaya. He was later investigated in Britain because of recurrence of symptoms, but no diagnosis was made. In 1966 he had been admitted to hospital in Belfast with features similar to the present episode, diagnosed as appendix abscess and treated conservatively. He failed to return for interval appendicectomy although he continued to get intermittent colicky abdominal pain, sometimes associated with diarrhoea.

*Examination.* Pulse rate and temperature were normal. There was a firm, slightly tender and mobile mass, about 3 inches in diameter, palpable to the right of and just below the umbilicus. Rectal examination was normal. A revised clinical diagnosis of Crohn's disease was made, and subsequent barium enema and operative findings seemed to confirm this.

*Investigations.* Haemoglobin and white cell count were normal. E.S.R. was 54 mm. in 1 hour. Faeces were weakly positive for occult blood. Sigmoidoscopy was normal to 15 cms. Barium enema showed a constant but non-specific narrowing of the proximal transverse colon.

*Operation.* At laparotomy on 14th September the previously palpated mass was found to consist of a relatively normal but low lying hepatic flexure, flanked by thickened oedematous segments of ascending and transverse colon, densely adherent to each other. The regional lymph nodes were enlarged but not hard. Right hemicolectomy was performed and the terminal ileum anastomosed to the left transverse colon.

*Pathology.* There were 2 segments of colon with thickened bowel wall, containing multiple mucosal ulcers, separated by normal mucosa. These ulcers were punched out in form and some had overhanging edges. Microscopic examination of these ulcers revealed a thick layer of necrotic debris overlying vascular fibrous tissue which was infiltrated with round cells and eosinophils. *Entamoeba histolytica* containing a single nucleus and red cells were seen in the depths of some of the ulcers.

*Post-operative course.* The patient had made a satisfactory and uncomplicated recovery by the time this report was received. However, a 10 day course of daily injections of emetine 65 mgm., supplemented by chloroquine phosphate 500 mgms. t.i.d. orally, was subsequently given.

## DISCUSSION

An amoeboma is a localized form of amoebiasis characterized by the formation of an inflammatory swelling in the large bowel due to recurrent amoebic and superadded bacterial infection. It involves the entire bowel wall with the periluminal fat and adjacent structures (Morgan, 1944; Hargreeves and Morrison, 1965). The sites most commonly affected are caecum, recto-sigmoid and anal canal (Morgan, 1944). The microscopic findings quoted in the case report are fairly typical. The incidence of amoeboma in cases of amoebiasis varies from 0–2.25 per cent in the larger recorded series.

The clinical picture depends on the site involved. There may be a long history of chronic ill health and recurrent diarrhoea. A mass may be palpable and Crohn's disease, appendix abscess, diverticulitis and large bowel carcinoma may have to be considered in the differential diagnosis. The onset may be more acute with obstructive symptoms. Rare complications include intussusception, perforation, localized abscess and hepatic involvement. Barium enema alone, while demonstrating a lesion in the colon, is not diagnostic. Features suggestive of amoeboma are the presence of relatively long segments of incomplete and sometimes non-rigid narrowing, often with normal mucosal relief (Druckman and Schorr, 1945). Failure to demonstrate parasites in faeces or ulcer scrapings does not exclude the diagnosis, though the finding of them is supportive evidence. The only absolute confirmation of amoeboma is a positive biopsy, and this is possible only when it occurs within reach of the sigmoidoscope. Rapid resolution of an amoeboma generally follows the administration of emetine, and a therapeutic test may be considered when the diagnosis is suspected.

Surgery is indicated if obstructive symptoms are acute, if subacute symptoms are not relieved, or if carcinoma cannot be excluded. A course of emetine should be given to cover the operative and post-operative period in proven cases and possibly in suspected cases. Without this precaution amoebic involvement of skin with extensive sloughing, formation of faecal fistula, fulminant exacerbation of colitis, dangerous haemorrhage, peritonitis, or even death, may occur. The likelihood of some such complication is so high that Seaton (1967) could claim that he knew of no patient, other than his own, who had proceeded to uncomplicated recovery following operation without the protection of specific anti-amoebic therapy.

## SUMMARY

A case of amoeboma of the colon successfully treated by hemicolectomy is presented. Despite the uncomplicated recovery the patient was undoubtedly put at risk by the failure to cover the critical post-operative period with specific anti-amoebic treatment, due to delay in making a diagnosis.

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